Lake County Health Department
and Community Health Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION

Rev. 1-15 (C)(H)

PATIENT NAME: _____

DOB: _____

MRN: _____

I hereby authorize the release of the following protected health information for the above named individual:

- ☐ Progress Notes
- ☐ Consultation
- ☐ Medication List
- ☐ Immunization Record
- ☐ Discharge Summary
- ☐ History & Physical Exam
- ☐ Laboratory Results
- ☐ X-ray Report
- ☐ HIV status
- ☐ Substance Abuse
- ☐ Psychiatric Assessment
- ☐ Clinical Assessment
- ☐ Treatment Plan
- ☐ Verify Presence
- ☐ Cooperation with treatment/attendance
- ☐ Letter (explain): _____
- ☐ Form (explain): _____
- ☐ Other (explain): _____

Specific Treatment Date: ____/____/____ Specific Treatment Date Range: From: ____/____/____ To: ____/____/____

NO LIMITATION will be placed on this release of information related to the testing, diagnosis and/or treatment of mental health, alcohol and/or substance use/abuse, HIV/AIDS, sexually transmitted disease or related conditions.
If desired, please indicate information to be LIMITED/RESTRICTED: _____

☐ Electronic Copy ☐ Paper Copy

FROM:	**TO:**
Name/Facility: _____	Name/Facility: _____
Contact: _____	Contact: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

The above information will be used for the following purposes:

- ☐ Case Review
- ☐ Continuing/evaluating treatment or program
- ☐ Coordination of services
- ☐ Determining eligibility for benefits or programs
- ☐ Legal
- ☐ Family/Significant Other contact
- ☐ School/Daycare
- ☐ Other: _____

Consequences of refusal to consent, if any: _____

This authorization is valid until: _____
(Month/Date/Year NOT TO EXCEED ONE YEAR)

Signature: _____ Date: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian

Signature of Witness: _____ Date: _____

I understand that I may revoke this authorization at any time by providing written notice to LCHD/CHC.

☐ I withdraw/terminate this authorization, effective _____ Signature _____ Date: _____
(Effective Date) (Client signature)

I understand that information disclosed as part of this authorization may be subject to redisclosure by the recipient and is no longer protected by law. This authorization will expire one (1) year from the date of signature, unless revoked earlier in writing and I hereby release Lake County health department and Community Health Center from any liability by releasing this information.

I further understand that **released information may not be re-disclosed** to any other person or organization without my written consent. This is in compliance with the Federal Regulations Governing the Confidentiality of Alcohol and Drug Abuse patient records, as noted in 42 CFR, Part 2.32 (a), or in compliance with the Illinois Mental Health and Developmental Disabilities Act]. If I decide to approve redisclosure of information, I understand it will not be protected by the Privacy Rule. I further understand that I have a right to inspect and/or receive a copy of the medical information to be released and also receive a copy of this authorization. I further understand I may refuse to sign this authorization and I understand my refusal to sign will not affect my ability to obtain treatment.

FOR OFFICE USE ONLY:	____PICK-UP	____MAIL	____FAX